CASE RECORD

APRIL 2012 SESSION

CERTIFICATE

This is to certify that this work titled "CASE RECORD" submitted by Dr. R.KARPAGAM ,as a part of fulfilment of the requirements for the Diploma in Psychological Medicine course of The Tamil Nadu Dr. M.G.R Medical University is an original and bonafide work.

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CASE 1

IDENTIFICATION DATA OF THE PATIENT:

NAME - Mr. R,

AGE - 46years old

SEX - male,

MARITAL STATUS - married,

EDUCATION - 5th standard,

LANGUAGES KNOWN - Tamil speaking,

RELIGION - following Hinduism,

RESIDENCE - hailing from Chennai

SOCIO ECONOMIC STATUS - LSES.

INFORMANT:

Self and Wife

INFORMATION:

Reliabe and Adequate.

REASONS FOR CONSULTATION

Frequent anger outburst
Impulsive behaviour } since 11years of age

Perversive behaviour –past 10 years.

Binge drinking –past 3 months.

HISTORY OF PRESENTING ILLNESS:

Patient was apparently normal till 11 yrs of age with mild hard of hearing. Around that age he stopped going to school due to financial problem &started to go to work. He maintained well with family members and others without any

significant behavioural problems. At that time, once his uncle commented about his hearing impairment in front of others, which made him very much irritated; he left that place immediately. Even after reaching home, he continued to have extreme irritability and restless following which around 12.00 am at night. He went to his uncle's place by walk which was 5kms away and assaulted him. His uncle sustained severe injury. He ran back to home as the neighbours and others rushed to the place seeing the incident. After this as they were relatives , they didn't make much issue about that incident.

For the next 1 yr he started working as an unskilled labourer in his own village. He used to have a occasional anger outburst leading to quarrel in his work place and in his family circle either for trivial reason or if his hearing impairment being criticised by others.

Later, at 13 yrs of age, he came to Chennai with his elder brother and started working as an unskilled labourer in constructional work. He stayed along with his brother and other co-worker. At that time he was introduced to brandy by his friends, he used to consume about <90ml, once in 10-15 days.

At work place he would become angry, for trivial reason with his co-workers, when his work was criticised by them and used to have frequent quarrels with them; would also become very irritable when superiors used to criticise his work; but he wouldn't express anger towards them. This type of anger outburst was manifested on and off.

He got married at the age of 26yrs. Following-next day of his marriage, went for a movie with his wife, where he hold her hand. As his wife insisted him to take off the hand, he became gets tensed and left her in theatre. He came

out immediately, he felt that his wife doesn't have true affection towards him. His irritability turned out to frustration and sadness. He consumed excess alcohol. Under the influence of alcohol, he went home and made multiple cuts over his both forearm and thigh with blade. Later his family members saw his condition. He was treated symptomatically in nearby hospital.

6 months later, once her wife insisted him to quit smoking while he was under the influence of alcohol, he tensed up and hit her and injured himself with lit cigarette over his thighs. During that incident he also tore about Rs.10,000 which he had in his pocket.

His frequent quarrelling with his wife for trivial reason, followed by physical assault over her, gradually progressed within few months of marriage. His wife used to return to her mother's place and used to stay there most of the time in a year. After few days he was noticed to feel about his own act. And he himself persuaded her to return home. Even after returns home, he was unable to control his anger, leading to frequent conflict between them.

In due course of time, his anger outburst very much unmanageable even at his work place. During his supervisor work, when a particular work was not done according to his instruction, he used to shout at his co-workers even for minor reasons leading to frequent quarrel in his work place. He would absent himself for a day or two after that incident; but he denied it to his family members.

Hence he was brought to IMH and treated with T.carbamazepine200mg 101, T.Amitryptiline25mg 101. He continued the medication for next 3 months. His anger outburst reduced but not significant level. His behavioural disturbance

persisted and gradually got worsened.

4yrs later when he was alone, following a quarrel with his wife, he married another woman from his work place suddenly without anticipating the further consequences. Later he realised it and apologised to his first wife. He maintained relationship with both of them in separate houses.

His uncontrollable anger outburst and frequent quarrels present with the second wife also. Later he found that his 2nd wife had an affair with another person. She left him after a year. He didn't react much to this.

After this he himself realised that he couldn't control his sexual desire and he started having unprotected sexual contact with many women mostly from his work place. And also he started having sexual perversion like touching the females while they were walking alone in street by riding in his vehicle. He was having sexual gratification by handling female undergarments, wearing it and also by rubbing against the female parts in crowded places.

Meanwhile his anger outburst increased as before and he started breaking household articles even for trivial issue.

In 2008, he was seen in IMH and put on T.Imipramine25mg 002, T.Carbamazepine200mg101.His anger outburst mildly reduced and he discontinued drugs after 7 months.

By the end of 2009 his alcohol consumption gradually increased in frequency 4-5 times/week, the amount was 90-180ml of brandy. At times he used to sell few household articles for drinking. Following this, his wife left him for 3months.So he reduced his alcohol intake.

In 2011, his alcohol intake increased again but not at regular intervals

whenever he drank, he consumed around 5-6 bottles of beer/day starting from morning to till night.

By the end of April 2011, he was brought to IMH with c/o. Irritability, excessive anger outburst, binge drinking and increased sexual thought. From past 2months, he is not going for work telling he is sick and he is on regular treatment since then. He is on T.sertraline50mg110, T.Diazepam5mg001at present.

No h/o. Hearing voices/ seeing images.

No h/o. Pervasive low mood/ suicidal ideas/ suicidal attempt

No h/o. Violation of rules.

No h/o. Head injury/ Fever/ seizure/ loss of consciousness.

No h/o. Haematemesis/ malaena

No h/o. Withdrawal symptoms.

PAST HISTORY:

H/o. Moderate bilateral sensorineural hearing impairment since childhood.

H/o. Difficulty in near vision was prescribed with corrected glasses.

FAMILY HISTORY:

H/o. Alcohol abuse and frequent anger outburst in his father –died when he was at the age of 12 yrs.

H/o. Suicidal attempt in his younger sister. First time-by consuming tablets. Second time-by hanging; but she was saved by their relatives.

H/o. Alcohol usage in his elder brother.

PAST PERSONAL HISTORY:

Early Childhood:

Antenatal history suggestive of Mumps in third trimester.

Full term normal delivery, born of non-consanguinous parent.

No h/o. Neonatal jaundice/ fever/ seizure.

Developmental milestones were normal.

Middle Childhood:

He joined school at the age of 6 yrs, but he was irregular to school. Most of the time, he used to play with other children in the village. He studied up to fifth standard.

No h/o. Stealing/ lying/ conduct disorder/ doing cruelty to animals.

Late Childhood:

From the age of 10yrs he started going to work. In his work place, he had frequent quarrels with his co-workers. Hence he couldn't work effectively.

MARITAL HISTORY:

He got married at the age of 26 yrs. He has 2 male children aged 15 & 19 yrs. He had frequent conflict with his wife and he doesn't have much emotional attachment with children. Hence his children were grownup in his mother in law's house. He also avoids to attending the social gatherings.

SEXUAL HISTORY:

No h/o. Pre marital contact.

H/o. Multiple extramarital contact in his work place.

H/o.Fetichism, Fetichistic transvertism and Frotteurism present.

SUBSTANCE HISTORY:

H/o. Alcohol usage since 10 years of age.

First he tasted toddy, when he was asked to buy toddy by his father nearer to their house.

H/o. Smoking was present initially. But he quit it after his quarrel with his wife.

LEGAL HISTORY:

No h/o. Pending legal case on him.

PHYSICAL EXAMINATION:

Alert

Ambulant

Afebrile

Healed multiple linear scars on both upper and lower limbs+

CVS-S1, S2 +

RS- NVBS +

P/A- Soft, no organomegaly.

CNS- 8^{TH} Nerve conductive deafness +

MENTAL STATUS EXAMINATION:

General Appearance and Behaviour:

Dressed adequately with unshaven face with well kempt hair, co-operative for the interview, elaborate detailed most of his complaints.

Gaze contact made.

Rapport established.

Psycho Motor Activity- normal.

No Tics or mannerism noted.

Speech:

Relevant and coherent.

Increased quantum and rate with normal tone and reaction time.

Prosody maintained.

Thought:

Form- normal.

Stream- normal.

Content- no delusion.

Emotion:

Mood- Euthymic.

Affect-reactive/ appropriate/ broad range/ no lability.

Cognitive functions:

Attention aroused

Concentration - sustained.

Oriented to time, place and person.

Memory- short and long term are intact.

Intelligence – average.

Abstract thinking – intact.

Judgement:

Personal –intact.

Hypothetical – intact.

Insight- grade 4.

PROVISIONAL DIAGNOSIS:

Emotionally unstable personality disorder.

INVESTIGATIONS:

Routine blood investigations: within normal limits.

CT Brain – normal study.

EEG – Normal study.

HIV, VDRL – non reactive.

Neurologist opinion –Nil Neurological intervention needed.

PSYCHOLOGICAL ASSESSMENT:

It was done to assess the extent of his symptoms and Psychopathology.

The following tests were given,

1.Symptom Sign Inventory- used to rate the symptom pattern on various diagnostic categories.

2.Eyesenck's Personality Questionnaire- to assess the personality and to arrive at a diagnosis.

3.Sentence Completion Test- semi projective test- to assess his adjustment in various areas.

4.Thematic Apperception Test- structured projective test- to assess his interpersonal conflict and his ways of dealing with the surroundings.

5.Rorschach Psycho diagnostic Test- unstructured projective test- to assess his personality organisation and also to aid in diagnosis.

TEST FINDINGS:

On assessment this person with multiple sensory impairment with marked resistant to correct himself with external aids. He manifested disproportion of anxiety with impulsive nature coloured by psychotic vulnerability and alcohol abuse in the background of inadequate personality.

Eyesenck's Personality Questionnaire- score more on psychotic and lie.

Sentence Completion Test- shows psychological conflict due to sensory impairment.

This patient need active psychosocial management based on conflict, tolerance

and specific cognitive deficit in arithmetic and non verbal memory(anxiety reduction method and increasing the coping skills).

DIAGNOSTIC FORMULATION:

46year old male with c/o. Frequent anger outburst- since 11 years, Impulsive behaviour, Perversive behaviour –10 years, Binge drinking -3 months, H/o. Moderate bilateral sensorineural hearing impairment since childhood. Family h/o alcohol abuse and frequent anger outbursts in father, h/o. Suicidal attempts twice in his younger sister. Physical examination- WNL. MSE- Alert, Ambulant male, dressed adequately, hair kempt, co-operative for the interview, gaze contact made, rapport established, motor activity- normal. Speech- Quantum and rate increased, tone- normal, reaction time –normal. Thought: Form and Stream- normal, Content- no abnormal beliefs. Perception- no perceptual disturbances. Mood- euthymic, Affect- reactive, broad, appropriate, no lability. Attention- intact, concentration- sustained, Oriented to time, place and person. Short term and long term memory – intact, Intelligence- average, Abstract thinking & Judgement- intact. Insight- grade 4.

FINAL DIAGNOSIS:

ICD 10 F60.3 Emotionally unstable personality disorder.

F60.30 Impulsive type.

MANAGEMENT:

PHARMACOLOGICAL:

T.Olanzapine2.5mg 0-0-1

C.Fluoxetine20mg 1-1-0

T.Sodiumvalproate200mg1-1-1

PSYCHOLOGICAL:

Psycho education to the family about his illness, course of the illness, the need for continuous drug treatment was given.

After the control of symptoms anxiety reduction methods and increasing coping skills training can be given.

Reality oriented approach was effective in this patient.

Dialectical Behaviour Therapy can be given.

The importance of drug compliance has to be stressed.

CASE 2

IDENTIFICATION DATA OF THE PATIENT :

NAME -Mr.V,

AGE -33yrs,

SEX - Male,

MARITAL STATUS - unmarried,

EDUCATION -10th std,

LANGUAGE - tamil speaking,

RELIGION -following Hinduism,

RESIDENCE - hailing from Vadalur.

SOCIO ECONOMIC STATUS - Belonging to LSES.

INFORMANT(S):

Self and Friend.

Information: Adequate.

Reliability: Fair.

PRESENTING COMPLAINTS:

Feeling that his body is developing feminine features
Increased breast size
Weight gain
Loss of facial & body hair
Softness of body
} 2years

Feeling low
Lack of concentration & interest
Decreased communication
} 1year

Decreased sleep & appetite

Suicidal attempts

Insidious – onset.

Course – progressive.

No precipitating stressors.

HISTORY OF PRESENTING ILLNESS:

Patient was apparently normal 2years back. He was working as a painter, regular to work. He was living alone as his parents expired and his sisters are married.

He noticed that his body weight is increasing gradually and he also noticed that his breasts are increasing in size gradually, after he noticed these changes he felt that his body is developing feminine features and slowly he is becoming a female.

He also felt that his body is becoming softer comparatively it was hard before. He felt his abdomen increasing in size and becoming softer as females, he feels even if abdomen size is increased in males it will be hard and not soft as females.

He also noticed that he is losing hair from his moustache, he has reduced his frequency of shaving his beard as it takes around 20 days to re grow and previously it grew within a week. He also felt he is losing hair from other parts of his body like chest, legs and arms. All these features made him think that he is acquiring female characteristics and day by day he is changing into a female gradually.

3months before all these symptoms started he consulted an astrologist to

know about his job opportunities and then he was told to be possessed by a female evil spirit, he didn't give much importance to it but now when he noticed all these changes in his body he thinks probably because of the evil spirit, he is changing in to a female.

He was falling ill very often and he read in books that drinking tulsi water put in copper vessel would increase his immunity, so he did it regularly and now he feels probably that also contributed to his present problems. He was regular to work, there was no sleep or appetite disturbances.

These symptoms continued for another 1 year, after this he felt that his breast is enlarging still further; he also felt that his legs are becoming slant like female, previously it was straight like males.

Following this he approached an astrologist again and performed some rituals which didn't improve his symptoms.

He also feels that people watch him and get to know that he has female attack by seeing his increased breast size and they know he is changing in to a female. Following this he started thinking too much about his symptoms and was preoccupied most of the times, he was frequently checking mirror for body changes. He was not able to concentrate on his work, he had difficulty painting the roof as his breasts felt heavier. Gradually he lost interest in many activities like going out with friends, watching movies which he enjoyed before. He reduced communicating with people previously he spent lots of time with his friends but now he hardly speaks to them.

His sleep gradually decreased, he sleeps around 3am and wakes up by 7am, till then he either watches TV or sits out his home and keeps thinking

about his problems.

Sometimes he wakes up in between his sleep with his heart beats racing which lasts for 1-2 minutes and later falls asleep. It was not associated with sweating or breathlessness.

His appetite also gradually decreased, he eats only half the quantity of food compared as before.

Following this he felt his life is not worth living, his future seemed dark to him. So he decided to end his life by hanging himself. He went with a rope to a tree behind his home in the night, later realised that he has 50,000 debts which he spent for his sister's wedding and felt after his death his sister would have to settle it. So he came back home dropping his suicide plan. In the past 1 year he has made 4 such attempts and every time he came back thinking of his debts.

Following this he consulted sexologist in Chennai, he was told that till his 58 years of age his hormones might change and he has chances of converting in to female. He was advised blood investigations and asked to come back.

2 months back he again approached another astrologist and performed some rituals which didn't improve his symptoms. He was advised by one of his friends to consult in IMH. So he came here.

No h/o. Hearing voices.

No h/o. Thought broadcasting/ withdrawal/ insertion/ echo.

No h/o. Excessive happiness/ fear/ anxiety.

H/o. Fall from ladder 6 months back, there was no loss of consciousness or any injuries. He consulted a doctor and was treated symptomatically for his pain. No ENT bleed.

No h/o. Seizures.

No h/o. Recurrent thoughts or acts.

PAST MEDICAL HISTORY:

No h/o. DM/ Hypertension/ TB.

No h/o. Any surgeries in the past.

FAMILY HISTORY:

No h/o. Any psychiatric illness in the family

No h/o. Wandering behaviour/ mental retardation.

No h/o. Suicidal attempts.

No h/o. Substance use.

PAST PERSONAL HISTORY:

Early Childhood:

Details not available.

Middle Childhood:

He was put to school at the age of 5 years in English medium. He was average academically.

Interested in sports.

Not interested in cultural activities.

No h/o. Any conduct disturbances.

Late Childhood:

Scored 301/500 in his 10^{th} std. Later discontinued schooling and started working in rice mill because of financial problems.

No h/o. Any sexual exposure or substance use.

Adulthood:

OCCUPATIONAL HISTORY:

Working as a painter.

SUBSTANCE HISTORY:

Consumes alcohol since 10 years, once or twice in a month around 180ml of brandy. From the past 1 year frequency has been increased to twice a week, quantity is 180ml of brandy.

No h/o. Withdrawal symptoms. History not suggestive of dependence.

SEXUAL HISTORY:

No h/o. Orientation towards same sex.

No h/o. Any interest in transgender activity or playing sex role of opposite sex.

No h/o. Any heterosexual / homosexual contact.

Normal nocturnal emissions, masturbates frequently to reassure himself. Started masturbation at the age of 15 years twice a week, he identified himself as male and object of interest is female.

LEGAL HISTORY:

No legal cases.

PREMORBID PERSONALITY:

Extrovert

Humorous, cheerful.

Optimistic

Hobbies like playing cards.

No history suggestive of suspiciousness.

Believes strongly in astrology.

PHYSICAL EXAMINATION:

BP-110/80 mmHg.

Pulse rate-80 beats/ min, regular.

CVS-S1, S2 +

RS – Bilateral NVBS +

P/ A – Soft, non tender, no organomegaly.

CNS – No focal neurological deficit.

External genitalia – Normal.

Male secondary sexual characters – Normal.

No gynaecomastia.

MENTAL STATUS EXAMINATION:

General Appearance, attitude and behaviour:

Alert, ambulant, dressed appropriately, hair kempt, unshaven face, co- operative for the interview.

Gaze contact made.

Rapport established.

Psycho motor activity –Normal.

Speech – quantum/ tone / rate – normal. Reaction time – normal.

Relevant and coherent.

Uses the stock word 'female attack' frequently.

Mood – sad.

Affect – depressed, reactive, appropriate, no lability.

Thought:

Form –normal

Stream –normal

Content – Somatic delusion +

He feels his body is developing feminine features and he is changing in to a female day by day.

Ideas of Reference +

He feels people watch him and get to know that he is becoming a female by seeing his increased breast size.

No obscessions.

Perception:

No perceptual disturbances.

Cognitive functions:

Attention – intact.

Concentration – well sustained.

Oriented to time, place and person.

Memory:

Immediate – intact

Recent – intact

Remote – intact

Intelligence – average.

General fund of information – adequate

Able to do calculations.

Abstract thinking – intact.

Judgement :

Personal –intact

Hypothetical – intact.

Insight – grade

INVESTIGATIONS:

Routine blood investigation – WNL.

CT Brain –normal.

EEG – normal study.

HIV, VDRL ,HBs Ag –Non reactive.

Testosterone, FSH, Prolactin –Normal.

PSYCHOLOGICAL ASSESSMENT:

Tests administered:

1. Eysenck's personality questionnaire (EPQ).
2. Symptom Sign Inventory (SSI).
3. Mutiphasic questionnaire (MPQ).
4. Middle sex hospital questionnaire .
5. Positive and Negative Syndrome Scale (PANSS).
6. Hamilton Depression rating Scale (HAM-D).
7. Sentence Completion test (SCT).
8. Rorschach Ink blot test.

Behavioural observation:

He was co-operative for testing, eye contact was maintained, attention and concentration were adequate, talk was relevant. He could comprehend the instructions.

Rapport could be established.

TEST FINDINGS:

On MPQ, SSI, MPQ he gets significant scores on paranoid, depression and somatisation.

On PANSS he gets significant scores on positive scale which is characterized by delusion and ideas of reference.

On HAM-D he gets mild to moderate level of depression which is characterized as feeling of sadness, suicidal ideas, not interested in work, sleep disturbances and feeling of hopelessness.

On sentence completion test he has negative attitude towards father, he is preoccupied about his problem. He expresses feeling of unhappiness, unable to concentrate on works. He feels that his future looks bleak.

On Rorschach ink blot test he has below average productivity with adequate mentation. He is partially in touch with reality, percentage indicates low degree of interest in seeking relationship between separate facts of experience and achieving organised view of the world. Rorschach protocol with few responses, absence of colour responses emphasis on D response with high animal responses. Rejection of responses, below average popular responses suggestive of depressive elements with traces of psychotic thinking.

IMPRESSION:

From the psychometry he is found to have an inadequate personality and gets significant scores on somatisation and paranoid which is dominated by delusional symptoms with secondary depression with repeated suicidal attempts.

DIAGNOSTIC FORMULATION:

33 year old male with c/o. Feeling that his body is developing feminine features, Increased breast size, Weight gain, Loss of facial and body hair, Softness of body 2-years, increased 1year. Feeling low, Lack of concentration and interest, Decreased communication, Decreased sleep and appetite, Suicidal attempts- 1year. Physical examination –WNL, Normal external genitalia and male secondary sexual characters. No gynaecomastia. MSE –Alert, Ambulant male, dressed adequately, hair kempt, cooperative for the interview, gaze contact made, rapport- established. Psychomotor activity – Normal. Speech – Quantum, tone and rate- normal, reaction time – normal. Mood – sad, Affect – Depressed, reactive, appropriate, no lability. Thought: Form and Stream – normal, Content –Somatic delusion, Ideas of reference. Perception – no perceptual disturbances. Attention – intact, concentration – sustained, oriented to time, place and person. Short term and long term memory – intact, Intelligence – average, Abstraction and Judgement – intact. Insight –grade 1.

FINAL DIAGNOSIS:

ICD 10 F22-PERSISTANT DELUSIONAL DISORDER, SOMATIC TYPE.

F32.1 –MODERATE DEPRESSIVE EPISODE.

MANAGEMENT:

PHARMACOLOGICAL:

T.Olanzapine 5mg 1-0-1

T.Clonazepam 0.5mg 0-0-1

PSYCHOLOGICAL :

Family therapy – Psycho education to the family members about identifying precipitating stresses inside and outside the family and planning strategies for

managing and minimizing future stresses.

Interpersonal and Social rhythm therapy- to reduce the lability of mood to maintain regular pattern of daily activities.

CASE.3

IDENTIFICATION DATA OF THE PATIENT:

NAME -Master .Y

AGE - 10 years

SEX – Male child

EDUCATION -Studying second std in special school

SOCIO ECONOMIC STATUS -Belonging to LSES.

RESIDENCE -Hailing from Thambaram- Urban background

INFORMANT:

Father and mother

Information:

Adequate and consistant

Reliability –fair.

REASON FOR CONSULTATION:

Delayed developmental milestone since birth.

Hyperactivity, aggression towards others

Impulsivity } 7years

Self harming

Adamant behaviour

Increased for the past 4 months associated with sleep disturbance.

Not interested in academic for the past 3weeks.

Onset – insidious,

Continuous , progressive –course,

7years duration,

No obvious stress factor.

HISTORY OF PRESENTING ILLNESS

Master Y ,10 years old male child second born for a 3rd consanguinous parents with history of mother taking abortifacient in the form of two tablets for three days at the 40th (11/2 month) of LMP, as she thought that her husband will not be able to give proper (financial) care for that pregnancy. He already had not given proper financial care for her even before the pregnancy.

During the same period she developed dental pain and she consulted private dentist. The dentist advised tooth extraction, but hesitated to do it because of her pregnancy and explained the possibility of abortion. She took the risk of abortion willingly and proceeded with extraction with the same dentist as she expected an abortion after tooth extraction and did not do so.

Then she consulted gynaecologist for termination of pregnancy. She went to the operation theatre as per the advice of the gynaecologist for D&C. As she was being prepared in the theatre and when she saw the instruments, became afraid and ran out the theatre then out of the hospital.

She went to her mother's home, the pregnancy continued uneventfully. She delivered a male baby FTND in hospital without perinatal complications. After the baby was delivered with deformed Right pinna as like that his maternal Grand father. Cried soon after birth. Breast fed on the day of birth. Baby birth weight 3.2 kgs.

As the child started growing parents started to notice delaying attainment of

developmental milestones as the compare to their first child. He significantly noted a delaying attainments of language and adaptive behaviours. Attainments of various developmental milestones as per the mothers history as follows

MOTOR BEHAVIOURS:

Moves head laterally in prone position was achieved at 11/2 months (4wks).

Momentarily lifts head when prone was attained at the 2months (4wks).

Head holdings: lift head to 90% when prone attained at the 3 months.

Sits with support attained at the 7months (5months).

Sits without support attained at 10 months (8months)

Stand with support attained at 11 months (9months)

Stand without support attained at 12months (10months)

Walk well without support at 18months (14-15months)

Run well, throw ball at 2years.

ADOPTIVE BEHAVIOURS:

Follows the moving objects, even away from the midline was attained at the 4months.

Grasps objects, transfer objects from hand to other was attained at 2years (4-5months).

Claps hands was attained at 10 months.

Gives hand, held objects to mother was attained at 2 years (1year).

Makes a tower of 3-4 cubes was not attained up to 6 years.

LANGUAGE:

Turn head and responds to sound of a bell was attained at 6months (4wks).

Lough loudly attained at 5months (3months).

Produce incomprehensible sounds ‘ma’, ‘ba’ was attained at 12months (9months)

Used 1-2 words meaningfully at the age of 6years (1- 11/2 years).

Two word utterance- 8-9 years

Says ‘ Amma’ -6years.

Parts of the body identified at 6 years (2 years).

Colour naming attained at 7years after training (5 years).

He was able to telling his name when asked, that to after a special school training.

PERSONAL AND SOCIAL BEHAVIOURS:

Social smile was attained at 5months (2-3 months).

Recognize mother was attained at 4months (3months).

Takes food to mouth was attained at 7months (6months).

Response to restricted social play was attained at 12months (9months).

Wear simple garments – socks / shoes at 3 years (2years).

Unbutton to button was attained at 6 years (3 years).

Button the dress well was attained at 8 years (4years).

Dress without supervision was attained at 10years (5years).

Toilet training was attained at 8years (2years).

As a child initially from around 3years of age his parents noticed him to be a very active child (hyper active) involved in continuous playing and pacing inside the home for hours together without taking adequate food and rest.

They noticed him playing with a ball usually alone not even allowing his elder sister to play with him. He also found that was not mingling with other

neighbour children. He used hit his sister, she tried to play with him or takes play articles extent make her cry.

Parents noticed him to be very adamant as any other new relatives including his grandparents visit his house or any other child tend to visit his house, he used to push them out of the house in spite of their repeated warnings. He demands switch on the TV continuously, in spite of him does not watch any channel . If the TV was switched off, he started cry excessively till the TV has been switched on.

He used frequent quarrels with his elder sister even if she came to speak with him, initiated play with him, within few minutes he used to beat her continuously necessitating his parents to come and separate them. He would break also frequently any things of her. Hence his parents shifted the girl to the grand mother's place. Slowly noticed him to be very much hyperactive , as he frequently tries to run out of the house. Suddenly he used to run out of the house in the street which would very difficult even his father get him and bringing him back to their house.

When his parents try to control him, he was found to exhibit peculiar behaviours like nail biting, lips smacking, biting and clenching the teeth, biting wrist (R), biting his own tongue, banging the floor with his feet and jumping continuously. The behaviour would last till his demands are met even to the extent of the sustained bleeding due to his own act. Even if his demands are met he would break the articles within half an hour.

Parents found that he was totally not obeying to any of their commands even if he called for giving food, taking bath, preventing from being his sister.

Break any new articles brought for him or his sister.

He would never pay any attention to his parents or any elders and beat them, if they try to control him. They also have noticing to be more particular household things to be placed in a particular order. If the order was altered he would forces the mother to arrange the order, till his mother arranges it.

Also to insisted to mother to dress only according to his wishes mostly in chudidar.

These behaviours occurs nearly 4-5 times/ day. All these behavioural disturbances progress to next two years making him very unmanagable in home. They took him to the dept.of child psychiatry at ICH Egmore where he was evaluvated and diagnosed as a case of pervasive developmental disorder at the age of 5years. He was treated with T.Chlorpromazine25mg ½ 0 ½ . Parents were advised to join him in special school. On continuous treatment his parents noticed slight improvement in behaviour and he was joined in a special school in Porur.

Initial few days he would refuse to get dress for school. He would also create problems like shouting, crying loudly in the train, while his mother taking to school. Even in school sit himself alone looking in to the chair, doesn't listening to any classes and frequently looking outside, even his teachers forces him, he never listen to him.

He would also never speak or interact with any other children. If he was taken from his locking chair and was seated along with other children would become restless within few minutes, would beat them. If he was stopped, he would beat even teachers and would become calm , if he was placed alone in his

locking chair. He learned simple words – amma, mama at the end of the first year.

Slowly within 5-6months teachers also noticed him to show those behaviours like biting his wrist, lip biting, lips smacking, clenching the teeth and tapping the floor with feet, if they try to control him and change of any of his routine activity.

Around 6years of age (2006), one day early morning when he getting up from bed, mother noticed him to develop involuntary movements of tonic contraction of one side of neck associated with continuous starring for few minutes followed by sudden onset of tonic, clonic movements of (R) upper and lower limbs associated with froathing of saliva from the mouth lasting for 10minutes. The episode was associated with spontaneous micturition and defecation. He was found to be not responding any commands , not communicating to any one for about next 1hour. He was taken to private hospital and emergency treatment was given and referred to ICH Egmore.

There he was admitted for 1week, advised continuous treatment T.Carbamazepine200mg 11/2 0 11/2 along with previous medications. CT Brain taken at that time was found to be normal. EEG was done- record not available with the patient. His diagnosis was revised as Autism with mild mental retardation. He was advised to continue both tablets T.Chlorpromazine and antiepileptics along with speech therapy , continuous stimulation, Avoid watching TV. He put on regular treatment and in spite of that continued have seizure episode around once in a every 6months- 1year.

Last 4 years,

First episode- 6years of age (2006)

Second episode -7 years of age (2007)

Third episode -7 ½ years of age

4th episode – 8years of age (2008)

5th episode -9 years of age (2009)

6th episode – 10 years of age (2011)

Last seizure episode was on 1.1. 2011. In due course of time his behaviour disturbance persisted and now parents him to be turning more violent and restless.

Whenever particular devotional songs where played, he found become restless would shouted loudly, start crying till the songs are switched off. He was frequently run out off the house, breaking household articles even his own things , if he was prevented going out.

When his parents try to control him or his demands not met, he found involving in impulsive act like plucked his own tooth by himself. So for he was removed 5 of his tooth in similar way without even crying in pain after such acts. He was also found to be playing with knife without fear and not listening to his parents requests.

In school previously sitting in a locking chair, but at present he found to be restless, moving inside the classroom disturbing to others, not listening to teachers even trying to hit them, when he was called by his name.

His parents or teachers request to do a small tasks, he has found to be breaking any articles like water bottle and household items. He also found to be venting out him anger outburst, biting himself, biting his nail till getting

bleeding physically injured himself.

At time while watching violent and fight seen in TV, he would beat his mother and sister, any one nearby at that time and would laugh loud tone after such act.

He would looking his and whenever he felt sad or happy. He was found to be crying suddenly without any reason. He would also continuously sing certain cine songs by frequently repeating few words of that particular songs. Sleep disturbance for the past 4months with frequent awakening at the night.

These behavioural disturbances occur more frequently for the past 4months 15-20 time per days.

He was brought for these complaints to IMH admitted on 30.8.11 treatment T,Carbamazepine200mg 11/2 0 11/2 ,T. Chlorpromazine25mg 101.

Even in the ward used to be hyper activity restless, not listening to ward staff and doctors, not co-operating to interview frequent running out the room. He used to carry wire basket with water bottle in it throught day and during night even when he is sleeping.

No h/o. Recurrant high fever

No h/o. Projectile vomiting

No h/o. Head injury with LOC

No h/o. Jaundice

No h/o. Unedible object eating.

FAMILY HISTORY:

Born out of 2nd sibling. 3rd degree consangunous parent.

H/o. Seizure disorder in his paternal uncle.

H/o. Maternal uncle died at the age of 5years (?MR)

H/o. Suicidal death in his maternal grand father +

No h/o. Alcohol dependence / substance abuse.

No h/o. Congenital abnormalities in the family.

PHYSICAL EXAMINATION:

Alert

Afebrile

Ambulant

Height – 136cms.

Head circumference – 35cms.

Vitals stable.

No low set ears .

(R) ear pinna deformed.

No slanting of eyes.

Limbs and skin – normal.

No hyper flexibility of joints.

CVS –S1 ,S2 +

RS –NVBS +

P/A –Soft, no organomegaly.

Genitalia - normal

CNS :

Motor :

Tone & bulk –normal.

Reflexes –normal.

No tics / tremor.

Spine and cranium – normal.

No cerebellar signs.

No peripheral nerve thickness.

Gait – normal.

TEMPERAMENT TRAITS

1. Activity level- 95% of time spent in activity alone, restricted, stereotypy, solitary activity.
2. Distractability –more than 90% stimuli are allowed to alter behaviour.
3. Adaptability –not able to move to changes.
4. Attention span – predominant short attention span. Selectively able to sustain attention

MENTAL STATUS EXAMINATION:

Appearance, Attitude and Behaviour:

Dressed in clean, appropriately dressed. Takes seat without prompting but doesn't remain seated. Holds a knitted bag in his hand which he refuses to it go.

Does not look at the examiner, when interviewed. Interacts with his parents physically and emotionally and grabs all objects present on the table. But returs them when prompted.

Keeps biting his hands, wrist, tongue, bangs table, sings a few words, makes noise often, verbal/ motor stereotypy presents.

General motor activity increased.

Rapport not established.

No tics / tremor.

Talk:

Spontaneously recites few words /verses communication – simple words which are relevant to simple questions.

Poverty of talk.

Thought:

Form – could not be tested.

Stream – decreased.

Content – poverty of content. Verbal stereotypy noted.

Affect – no predominant affect. Range full.

Inappropriate at times.

Perception :

Could not be tested.

Cognitive functions :

Attention could be aroused but not sustained.

Memory, orientation, abstraction could not be tested.

Insight could not be assessed.

INVESTIGATIONS:

Routine blood investigation –WNL.

MRI – Brain normal study.

EEG –B/L Epileptic activity.

NEUROLOGIST OPINION:

Mental Retardation / Seizure Disorder / Autism / ADHD

PSYCHOLOGICAL ASSESSMENT :

Formal testing is not possible. However with possible testing childhood Autism Rating Scale and Vineland Social Maturity Scale, Seguine Form Board test showed marked impairment on relating to people. Difficulty to follows instruction. Severe amount of abnormal listening responses.

There was impairment of verbal and nonverbal communication. Also he showed severe amount of abnormal activity of hyperactive nature exhibit shift from one to other tasks.

His intellectual responses also not consistant, which is not appropriate to his age. Visuomotorfunction also impaired. His social age is lower than the mental age. But mental age also not matching with his chronological age, at present his mental age is 5 years.

IQ will be around 50. But this IQ may not be reliable comparing his scholastic skills, which his achieved through period of time by special training. That all could not able to at present.

IMPRESSION:

With this possibly of Brain damage with behaviour problem of mixed in nature, predominantly Autistic Nature.

The following tests were given:

RATING SCALE:

Brief psychiatric Rating Scale for children,

1. Un cooperativeness
2. Hyperactivity.
3. Distractability.
4. Emotional withdrawal.
5. Sleep difficulty.
6. Stereotypy.

DIAGNOSTIC FORMULATION:

Master Y ,10 years old boy, studying 2nd std in special school, brought by his parents with h/o. Delayed developmental milestones since birth and h/o. Hyper activity, Impulsivity, self harming behaviour with insensitivity to pain and adamant behaviour, Aggression towards others –for the past 7years, increased for the past 4months. Associated with seizure disorder for the past 5years on regular treatment, with last episode on Jan 2011. Associated with a family h/o. Seizure disorder in paternal uncle. ?MR in maternal uncle who died at 5years of age and h/o. Suicidal death in maternal grand father. General systemic examination WNL. MSE – revealing a young boy dressed appropriately, not interested in interview, with increased general motor activity associated with frequently biting his hands, wrist, tongue, banging the table and singing few words, making noises and with verbal stereotypy, communicating with few single words relevant to questions also spontaneously reciting few words with decreased stream of thought and poverty of content of thought, affect inappropriate at times with aroused attention and ill sustained concentration and patient not cooperative for further testing.

FINAL DIAGNOSIS:

F.84. PERVASIVE DEVELOPMENTAL DISORDERS WITH SEIZURE DISORDER

F.84.0 CHILDHOOD AUTISM

MANAGEMENT:

PHARMACOLOGICAL TREATMENT:

T.Carbamazepine 200mg 1-0-1

T.Haloperidol 1.5mg ½- 0- ½

T.Benzhexol 2mg ½- 0 -½

T.Diazepam 5mg 0-0 -½

PSYCHO THERAPY :Supportive family therapy. The importance of drug compliance has to be stressed

CASE.4

IDENTIFICATION DATA OF THE PATIENT:

NAME -Mrs. M

AGE - 35years,

SEX – female,

EDUCATION -Studied up to 6th std,

MARITAL STATUS -Married ,

SOCIO ECONOMIC STATUS -Belonging to LSES.

INFORMANT:

Husband

Information :

Reliable and adequate.

REASON FOR CONSULTATION:

Headache - 5years

Hearing voices – 7months

Worsening of headache 5 months

Dull and withdrawn

Not doing household work

Lack of personal care

Claiming lack of energy

Suicidal ideas

} 3months

First episode,

Insidious onset,

Progressive illness.

HISTORY OF PRESENTING ILLNESS:

Mrs. M was apparently normal 5 years back. She started to experience headache on both side occur in the temple region, and expanding to all over the scalp. It was mild in severity and was static throughout the day without obvious precipitating factor. She after experiences burning sensation over the palm and feet at times. As the headache was continuous, consulted general practitioner, advised spectacles which didn't follow.

She continued to live with headache and maintained self and family and starting from 7months back, she heard some unknown male voices calling her by name at night during sleep. She would wake up and search for them in house. At times she would feel calling with gestures by their hand, while hearing voices and slapping her. She would continue to experience for most of the day in a month at night time.

4 months back, she started to hear the voices even when she awake. One night she wanted to search out of home as she continued to hear some 7 male voices calling her by name. Her husband needed to resist her.

From then she continued to hear voices irrespective of day or night.

3 months back, her son was admitted in a hospital following severe abdominal pain and was said to be operated for some growth in intestine which was later said to be normal in another hospital.

From that time she started to be dull and withdrawn. She had avoided interacting with other family members and would claim of feeling sad and would complain of burning sensation spreading from head down upper limb,

back, genital region , lower limb and feet.

She would complain of lack of energy, when her husband asked to do maintain home and household work and simply sitting and lying in the bed.

She would not maintain her personal care and take food. Needed to feed, taking bath, brushing and even changing and adjusting clothes. She would simply sit and reply occasionally after continued questioning. She had expressed suicidal ideas on her own.

She continued like that for about 20 days and then was taken to Meenakshi hospital for general consultation, where she was investigated routine blood investigation including Thyroid Function which have said to be normal. Then she was referred to Psychiatrist, where she was diagnosed as Acute Stress Reaction with Depression and treated with T.Dazide 50mg , T.Lorazep 0.5mg 102, T.Olanz 5mg 101, T.Nitrzepam10mg 001

For the last 2months, she had improvement in slowness of activities and speech. She started to have the feeling of running out of home, getting suicidal ideas. She felt herself worthless to her, but hadn't attempted to do so. Her sister used to console her whenever she expressed such ideas.

She could not involve in previously pleasurable activities and continued to have headache, not able to do household works.

She hadn't heard voices for the last 1 month. As she was not affordable for medicine, she came here for consulation.

No h/o. Head injury / LOC /Seizure /fever.

No h/o tall claims /elated mood /excessive spending.

No h/o. Repetitive act

No h/o. Excessive fear /Tremor /sweating / palpitation.

PAST HISTORY:

H/o. Fits during 2years of her age- once , details not known.

No h/o. Physical illness in the past.

FAMILY HISTORY:

H/o. Alcohol abuse in her father.

She is the fourth born of the 7 siblings. Born of third degree consanguinous marriage.

No h/o. Mental illness, suicidal, absconding behaviour in the family.

PERSONAL HISTORY:

Early childhood:

Full term normal delivery; home delivery, cried immediately after birth. No h/o. Neonatal jaundice / seizure.

Normal developmental milestones

Middle childhood:

Joined school at the age of 6years, goes to school regularly. Average scholastic performance. No h/o.conduct disorder.

Late childhood:

Education :

She studied up to 8th std, then she discontinued her studies due to financial problem.

MENSTRUAL HISTORY:

She attained menarche at the age of 15 years. Irregular cycle.

MARITAL HISTORY:

She got married at the age of 17 years. She has 3 children aged 18, 17 and 15 years. PS done 10 years back.

No h/o. Marital disharmony.

LEGAL HISTORY:

No h/o. Pending legal case on her.

PREMORBID PERSONALITY:

Sociable – well interacted with family members and adjustable .

Low self esteem – used to lament during critical situations like debt and medical illness of her children.

Maintained home regularly.

Religious

PHYSICAL EXAMINATION:

Alert

Ambulant

Afebrile

Not anaemic / jaundiced / cyanosed .

No clubbing / pedal edema.

CVS –S1 ,S2 +

RS –clear. NVBS+

P/A – soft, no organomegaly.

CNS- no focal neurological deficit.

Cranial nerves – normal.

Motor , sensory and autonomic nervous system – normal.

Cerebellar functions – normal.

Gait – normal .

MENTAL STATUS EXAMINATION:

Young female dressed adequately, in touch with surroundings, keeps nodding her head, less responsive to surrounding, crying in between.

Rapport established with difficulty.

Gaze contact made and ill sustained.

Psychomotor activity – reduced.

Speech –relevant and coherant.

Quantum and rate – reduced.

Talks mono tonously.

Reaction time – prolonged.

Thought :

Form : normal

Stream : reduced.

Content :

Ideas of worthlessness. +

Ideas of hopelessness +

Suicidal ideas +

Perception – no perceptual disturbances .

Mood – sad

Affect – appropriate / no lability.

Cognitive function:

Attention – aroused.

Concentration – ill sustained.

Oriented to time, place and person .

Memory :

Recall – impaired.

Recent and remote – intact .

Intelligence – average .

Abstact thinking – intact.

Judgement :

Personal - impaired.

Hypothetical – intact.

Insight –grade 4.

LABORATORY INVESTIGATIONS:

Routine blood investigations –WNL.

CT Brain – normal.

EEG – normal study.

HIV, VDRL –non reactive.

NEUROLOGIST OPINION:

Nil neurological intervention needed.

PSYCHOLOGICAL ASSESSMENT:

The following tests are given;

1.Symptom Sign Inventory

2. Eysenck's Personality Questionnaire

3. Sentence Completion Test

4. Thematic Apperception Test

5. Rorschach Psycho diagnostic Test

6.Hamilton Rating Scale for Depression

7. Montgomery Asberg Depression Rating Scale

TEST FINDINGS:

She was cooperative for testing and slow in her responses. Her attention was aroused and concentration ill sustained. She took long time to answer.

This person on psychiatric treatment assessed with psychological tests for personality and psychopathology.

Marked subjective distress noted of uneven nature, with the evidence of recurrent thoughts traumatic nature.

On assessment as per personality and projection testing shows basically a person of obcessive traits manifestation features. Depression and paranoid in the areas of mood and referential thinking suggestive of gross psychopathology coloured by the personality (premorbidly -neurotic), traumatic thoughts of sexual nature and maladaptive sexual behaviour with husband.

No schizophrenic features noted.

To achieve complete recovery, she has to been regularly for psychotherapy and CBT with her husband.

DIAGNOSTIC FORMULATION:

35years Mrs. M, brought by her husband with c/o. Headache – 5years, hearing voices – 7months, worsening of headache -5months, dull and withdrawn, not doing household work, lack of personal care, claiming lack of energy, suicidal ideas- 3months. H/o. She had been treated privately- 2months back and fits during 2years of her age. Family h/o. Alcohol abuse in her father. H/o. Irregular menstrual cycle with normal thyroid function . Physical exam-

normal. MSE- dressed adequately, in between crying, rapport established with difficulty, motor activity –reduced, speaks monotonously, quantum and rate-reduced, reaction time – prolonged. Thought – stream –reduced, content- ideas of worthlessness, ideas of hopelessness and suicidal ideas are present. No perceptual disturbances. Mood –sad , affect- depressed, no lability, full range. Attention aroused, concentration ill sustained, oriented to time, place and person. Memory –recall is impaired. Personal judgement is impaired. Intelligence – average. Insight- grade.4.

FINAL DIAGNOSIS:

F.32.DEPRESSIVE EPISODE

F.32.3 SEVERE DEPRESSIVE EPISODE WITH PSYCHOTIC SYMPTOMS

MANAGEMENT:

PHARMACOLOGICAL TREATMENT:

T.Olanzapine 5mg 1-0-1

C.Fluoxetine 20mg 1-1-0

PSYCHOLOGICAL TREATMENT:

Psycho Education to the family members about her illness, the need for continuous drug treatment was given.

After the control of symptoms, individual psychotherapy (CBT) can be given.

Interpersonal and social rhythm therapy – to reduce the lability of mood to maintain regular pattern of daily activities.

Improving coping skills training to be given.

CASE 5

IDENTIFYING DATA OF THE PATIENT:

NAME- Mr . F ,

AGE -34 years ,

SEX - male,

EDUCATION - Discontinued 6th standard,

MARITAL STATUS - Unmarried,

OCCUPATION - Car driver by occupation,

SOCIO ECONOMIC STATUS - Belonging to LSES,

RELIGION – Islam,

LANGUAGE- Urdu and Tamil speaking,

RESIDENCE - Hailing from new avadi road, Chennai.

INFORMANT (S):

Mother and self.

Information:

Adequate

Reliability – fair and consistant.

REASON FOR CONSULTATION:

Frequent somatic complaints with consulting frequent Doctors

Frequent intake of certain drugs over the counter

Multiple suicidal attempts (4attempts)

Not going for work

Sleep disturbances

} 6years

Dull and withdrawn

Poor self care

Suspiciousness
Aggressive / Assaultive behaviours
Using abusive words
Talking to self / laughing to self
Wandering tendency
} 3months

Insidious in onset, continuous and progressive course

Duration – 6 years.

No precipitating factor.

HISTORY OF PRESENTING ILLNESS:

Mr. F was normal 6 years back. He was working as a car driver. He was regular at work, earned 500-600 rupees /day. ¼ th of money gives to the mother for household purpose, remaining money spent with his friends. After spending with his friends, went home late in the night regularly. Most of the time spend with his friends. During that time, he used smoking cigarettes and panparag, super pakku and occasionally use cannabis and alcohol- six months once.

He slowly developed multiple somatic complaints like headache, ear ache, nasal block, mouth ulcers, body tiredness, weakness of limbs, abdominal pain, nausea and digastric problems. He took frequent consultation with frequent doctors treated symptomatically. He was not satisfied. Instead of that he also frequently took certain drugs (steroid, analgesics) over the counter for the same complaints.

One day he consulted one new physician for the same complaints. After finishing his clinical examination, he said these are the complaints also occur in HIV/AIDS patient. He enquired about any contact with a commercial sex worker. He accepted his contact with a commercial sex worker 9 years ago. Doctor gave reassurance and advised regarding HIV awareness and precaution. He was apprehensive and preoccupied that he had HIV. He did a blood test to find out whether he had HIV, the blood result was negative. He was also worried as his parents were unconcerned about his marriage. Gradually he become dull and withdrawn, not going to work, sitting idly. His intake of food decreased. He neglected his self care. He had to be forced by his mother to take bath and change dress. He attempt suicide by using insect poison and oleander seeds. He never expressed these ideas to anybody, he not make a suicidal notes. The attempt was made when no one was present. The attempt was made at afternoon (2pm). He vomited soon (1hr). His mother return back from work , she took him to the hospital. Then treatment was given. She brought him to IMH on 30.6.04. He was diagnosed as a case of Anxiety with Depression. He was treated with T.Amitriptyline5mg.

After 6months of treatment, he began to be preoccupation with his penile erection and same multiple somatic complaints. His diagnosis was revised as somatoform disorder with co morbid depression. He was treated with T.Citalopram 10mg 200, T.Clonazepam 0.5 mg 001.

After one year of treatment, he became active. He started taking food regularly. He started going to work, sleep pattern was improved. So he discontinued the treatment. Within one month of discontinuation, he attempted

suicide by pouring of kerosene over his body and setting fire to himself. He never expressed these ideas to anybody. He did not make a suicidal notes, the attempt was made when no one was present. He sustained 27% burns. Burns over the both arms, upper chest, throat, hands and neck region. He was treated at KMC –GH. During his treatment in KMC-GH, he developed the belief that the surgeon forcefully anaesthetised and implanted a machine inside his chest. After discharged from KMC, he believed that his body image had changed. On looking at the mirror, he believed that the image was not his face and body. He believed that the image was of dirty and ugly person. He attributed this change to be the result of some black magic done by his friends. He was treated with T. Olanzepine 5mg 101, T.Nitrazepam 5mg 001, T.Amitriptyline 25mg 002.

After 2 months of treatment, he developed c/o.increased time to attain erection, reduced sexual desire. He also had decreased interest in daily activities, lack of concentration at work. Following which T.Olanzepine was stopped.

He was treated with C.Fluoxetine 20mg 110, T.Nitrazepam 5mg 001. On continuous treatment, his sexual dysfunction improved. He started going to work, while he was continuing treatment. He began to hear voices during the day time, when he was alone. The voices belonged a group of unknown person (male or female) discussing about him and commanding on his activities. He also suspected that, his mother and his friends performed black magic on him which was responsible for his present symptoms. He suspected that, when he used to go out of his home people on the road where discussing about him. He was diagnosed as schizophrenia paranoid type. He was treated as an out patient.

After one month of treatment, he was brought by his mother seeking admission. He was treated with the following drugs. T. Olanzepine 5mg 112, T.Diazepam 5mg102 and 5citing of ECTs given. He improved and discharged after 20 days and prescribed T.Chlorpromazine 100mg 002, T.Benzhexol 2mg 001,T.Nitrazepam 5mg 102,T.Amitriptyline 25mg 112. He continued treatment for 1 year. After that became irregular and discontinued treatment.

After 9 months of discontinuing treatment, began to believe that his life was in danger. He believed that a group of person were following him with weapons and chasing him in auto, when he was outside the house. His mother later verified to be false, but he did not change his beliefs. He did not go out to walk and remained inside his room.

He stopped go to work. His self care began decline. Sleep was disturbed. He took pills in order to sleep. He stopped taking food because he believed that his food was poisoned by his mother. He stopped communicate with his family members.

These above symptoms were present 4-5 days, after which he developed belief that neighbours are talking in the street about him and became irritable. He was found to be talking to self and smiling inappropriately. He used abusive language and scolded his family members. He assaulted his mother many times, this aggressive behaviour was always following arguement. He believed that an machine implanted and placed inside his chest, when he was admitted for burns at KMC-GH is now under the control of politician whoever trying to burn his body through heat produced by machine, because of this he has lost weight and he has become short by several inches.

He wander away from home several times, but comeback same night. 20 days back ,he went along with mother to vellore to relative house in order to remove the implanted machine by surgery with their help.

1 week back, in the afternoon when he was alone he was found to be chewing something. His sister noticed it as glass pieces in his mouth. He was brought to IMH where he referred to KMC-GH for further treatment.

No h/o. Increased energy and activities

No h/o. Spending spree.

No h/o. Colourful dressing.

No h/o. Repeated checking and washing

No h/o. Excessive fear for particular place.

No h/o. Crying spells.

PAST MEDICAL HISTORY:

No h/o. DM / HT/ BA /Jaundice

No h/o. Head injury with LOC / Seizure.

FAMILY HISTORY:

H/o. Alcohol dependency in his father.

No h/o. Epilepsy / mental retardation

No h/o. Substance abuse in the family.

No h/o. Suicidal death in the family.

PAST PERSONAL HISTORY:

Early childhood:

Full term normal delivery in home.

No birth complications.

No birth defects. No drug taken by mother during pregnancy. Breast fed.

Milestones were normal.

Middle childhood:

Preschool and school experiences good. He joined school at the age of 5 years. He was discontinued at 6th std. Had many friends and playful. No fever/ surgery/ trauma.

No night mares/ phobias / bed wetting / fire setting.

No history suggestive of temperamental problems like head banging / temper tantrum.

Late childhood:

Attitude towards siblings / playmates – good.

Short temper

Sensitive to criticism

Adulthood :

EDUCATION :

Discontinued 6th std, because of interest to study.

OCCUPATION:

Car driver. No work related conflicts.

SEXUAL HISTORY:

H/o. Pre maritalcontact present

SUBSTANCE HISTORY:

H/o. Frequent drugs taken for inducing sleep

H/o. smoking beedi-6-7 /day

H/o. Panparag usage present

H/o. Alcohol / cannabis usage occasionally, not dependance

Pre morbid personality:

Extrovert

Sociable

Short temper

Sensitive to criticism

Mingle with friends

Spend more time with friends ,came late to home.

PHYSICAL EXAMINATION :

Thin built

Moderately nourished

Not anaemic / jaundiced /cyanosed

No clubbing / pedal edema

Healed burn scar over the chest, throat, arms and both hands

BP -120 / 70 mmHg

PR -80 / min, regular.

CVS –S1 ,S2 +

RS – NVBS+

P/A –Soft , no operative scar over the abdomen and chest

CNS – no focal neurological deficit.

MENTAL STATUS EXAMINATION:

Appearance , behaviour and attitude:

Patient is thin built and moderately nourished, dressed adequately, unshaven face, not well groomed.

No abnormal behaviour noticed.

He is attentive , interested and cooperative.

Gaze contact made and sustained.

Rapport established.

Psychomotor activity –normal.

No mannerism, tics, gesture,twitches, stereotyped behaviour, rigidity, flexibility, restlessness and wringing of hands.

Speech –

Quantum , tone and rate –increased.

Reaction time – decreased

Spontaneous excessive speech present

Thought :

Form – circumstantiality +

Stream – increased

CONTENT:

Bizarre delusion –

He believes that a machine was placed in the chest by doctors at KMC-GH by performing a surgery. Now this machine is to produce heat in his body and change to his body has become like a burning dry wooden log and they are also causing spontaneous seminal emission.

Ideas of reference-

He feels that when goes out of street, people are discussing about him.

Delusion of control-

The politicians are controlling his activities through the machine

Delusion of persecution-

The politicians are doing harm to him through the machine.

Ideas of hopelessness

Ideas of helplessness

Ideas of worthlessness

Feeling of suicidal ideas due to that machine.

Emotion :

Mood – sad (dysphoric)

Affect – appropriate , reactive

Perception – no perceptual disturbances

Cognitive function:

Alert

Attention – aroused

Concentration – sustained

Orientation :

Time –intact

Place -intact

Person – intact

Memory :

Short term – intact

Long term – intact

Intelligence – average

Abstract thinking – intact

Judgement :

Personal –intact

Hypothetical – intact

Insight – absent (grade -1)

LAB INVESTIGATIONS:

Routine blood investigation –WNL.

CT Brain – normal

EEG – normal study

HIV, VDRL – non reactive

Neurologist opinion- nil neurological intervention needed

PSYCHOLOGICAL ASSESSMENT:

TEST ADMINISTERED:

1. Symptom Sign Inventory
2. Eyesenck's Personality Questionnaire
3. Sentence Completion Test
4. Thematic Appreception Test
5. Rorschach Psycho diagnostic Test
6. PANSS Score
7. Hamilton rating Scale for Depression

REPORT :

Patient referred by psychodynamic assessment, behavioural observation . Eye contact maintained. Rapport established. Thought – answers relevantly , coherently. Increased talk output. Content of thought – paranoid. Attention could be aroused and sustained. Patient was able to comprehend instruction and test findings. BGT shows good visuo percetual functions good. Poor in recall. Symptom sign inventory scores elevated on depression and paranoid. Scale for the positive symptoms shows persecutory delusion , somatic delusion, delusion of reference and delusion of control. Global ratings of delusion are severe.

Aggressive ,agitated behaviour was present which is improved. On Hamilton depression scale get score of 21, suggestive of moderate level of depression and DAP shows psychotic tendency and Rorschach total responses given are 14 with average mentation time . Patient given from popular , 10 originals with fluctuation of form level rating , contact analysis shows animal human , mask and anatomical response and objective disturbance of colours.

IMPRESSION :

Patient with adequate cognitive functions with evidence of psychotic illness of paranoid schizophrenia with depression

DIAGNOSTIC FORMULATION:

34 years old unmarried male with multiple somatic complaints, multiple consultations, intake of over the counter drugs, multiple suicidal attempts, not going to work, sleep disturbance, dull and withdrawn, poor self care for 6years and suspiciousness, aggressive and assaultive behaviour, use of abusive language, talking and laughing to self and wandering. Insidious onset, continuous course with no precipitating stressor. Past h/o. Suicidal attempt, family h/o. Mental illness in grand mother and alcohol dependence in father. Past personal h/o. Multiple substance use sexual promiscuity. Physical exam- multiple healed burn scars. MSE- unshaved, not well groomed. Speech –QTR and Stream –increased. Reaction time – reduced. Thought – form:circumstantiality+ content- delusion of control and persecution + mood – sad , affect- inappropriate , Intact cognition and absent insight.

DIAGNOSIS :

F.20. SCHIZOPHRENIA

F.20.0 PARANOID TYPE.

MANAGEMENT:

PHARMACOLOGICAL :

T.Olanzapine 5mg 1-1-2

C.Fluoxetine 20 mg 1-10

T.Diazepam 5mg 0-0-2

PSYCHOLOGICAL MANAGEMENT:

Family education about his illness, symptoms, course of the illness and need for continuous treatment.

Cognitive Behaviour Therapy to be given after the control of symptoms. Improving coping skills training to be given.

Interpersonal and social rhythm therapy – to reduce the lability of mood to maintain regular pattern of daily activities.